Remarks by ONDCP Acting Director Michael Botticelli
U.S. Senate Forum on Heroin/Prescription Drug Epidemic &
Buprenorphine/Naloxone Expansion
Washington, D.C.
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Thank you, Senator Levin and Senator Hatch, for convening today's Forum. Thank you both for your leadership to reduce the stigma associated with substance use disorders and for your work on the Drug Addiction Treatment Act of 2000. Your work has made a difference– and most importantly, it has saved lives.

I am pleased to be here today to discuss the Administration's efforts to address the Administration's approach to drug policy. Our *National Drug Control Strategy (Strategy)* is based on science and evidence. It begins with recognizing that addiction is a brain disease that can be prevented, treated and from which one can recover.

Overdose deaths, primarily driven by prescription drug abuse, have surpassed auto crashes as the number one cause of accidental death. And along with the increase in overdoses caused by prescription drugs, we have also seen an increase in heroin deaths. Both heroin and prescription drugs are included in a class of drugs called opioids. They have a similar effect on the brain and can be successfully treated with medication-assisted treatment (MAT) such as buprenorphine and other FDA approved medications.

Overview of Strategy

Today, I would like to provide a brief overview of the Administration's *Strategy* and review the important role that MAT plays in addressing substance use disorders in our country.

The Obama Administration's Inaugural *Strategy,* released in 2010, established five year goals to reduce drug use and its consequences. A major component of the *Strategy* is integrating treatment for substance use disorders into mainstream health care. This includes the expansion of treatment in community health centers and improving the quality and evidence base of substance use treatment. Integrating treatment into mainstream health care will help increase access to treatment and close the significant treatment gap that exists for substance use disorders.

Treatment Gap and Need for MAT

According to the most recent data obtained from the *National Survey on Drug Use and Health*, only a small percentage (approximately 10 percent) of people with substance use disorders received treatment at a specialty facility.

The increase in the abuse of opioids, including prescription pain medications and heroin, has created unprecedented demand on the Nation's treatment system.

Long-term maintenance treatment with an FDA-approved medication for treating opioid use disorders or relapse-prevention combined with behavioral therapies – has been shown to be more effective than treatment without medication. Additionally, studies have shown that MAT can be cost-effective, prevent criminal recidivism and blood-borne infection from injection, and save lives by preventing overdose.[1]

There is consensus on the value of MAT. In 2007, the National Quality Forum standards of care to treat opioid use disorders recommended pharmacotherapy, linked with psychosocial treatment and support, for

all adult patients diagnosed with opioid dependence and without medical contraindications.[2]

MAT should be the recognized standard of care for opioid use disorders – and yet, for too many people it is out of reach.

In 2013, only 8 percent (1,167) of treatment facilities were certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide treatment with methadone and/or buprenorphine (*Opioid Treatment Programs).*[3]

Treatment programs are too often unable to provide this standard of care and there is a significant need for medical professionals who can provide modern care in an integrated health care setting.

The more than 1.1 million physicians who can write controlled substance prescriptions, only about 25,000 received a waiver to prescribe office-based buprenorphine. Of those, 7,600 had completed the requirements to serve up to 100 patients; the remainder can serve up to 30. Although they were augmented by an additional 1,378 narcotic treatment programs, only a small number of physicians are electing to use MAT for their patients.

MAT for opioid dependence is underused. A recent study of 345 private sector specialty treatment programs found that among the 266 programs that had access to at least one prescribing physician, adoption of each addiction treatment medication (methadone, buprenorphine, or naltrexone) had occurred in less than 50 percent of programs. The low rate of adoption of methadone was expected, since programs that exclusively offered methadone treatment were excluded. Among

programs that had adopted MAT, actual implementation (prescribing to patients) averaged only 34 percent across all medications combined.[4]

Federal Efforts to Increase MAT

To expand the use of MAT, my office convened a group of Federal agency representatives to review Federal programs, policies, and administrative authorities. This convening, called The Treatment Coordination Group, has been tasked with identifying barriers to MAT and to explore ways to increase MAT for opioid use disorders.

In addition, the Treatment Coordination Group seeks to coordinate individual Federal agency efforts to improve access to substance use disorder treatment; increase the quality of treatment services; and make sure systems are in place to adequately monitor the outcome of these services.

State Efforts to Increase MAT

A number of states, including Massachusetts, Vermont, and West Virginia, are also implementing treatment models to provide access to MAT services. We need to encourage other states to adopt such models to improve patient access to MAT.

Providing training and technical assistance to physicians and their teams interested in implementing these models is likely to help them become active providers of this highly effective outpatient treatment.[5]

For example, when I worked in Massachusetts, we implemented a nurse care manager model for MAT. We used this model for several reasons. The Commonwealth of Massachusetts was moving toward integrating

primary care services with substance use disorder treatment. There was an adequate number of physicians with DEA waivers to prescribe buprenorphine, although the prescribing rate was low.

We anticipated that as we implemented state-wide health care reform there would be an influx of new clients into the health care system who would need both primary care health services and substance use disorders treatment services. We therefore increased the capacity of primary care settings (Community Health Centers) to provide substance use disorders treatment services through the use of buprenorphine.

We also provided education to health care providers to increase their knowledge of substance use disorder treatment, and to build a payment system for sustainability of substance use disorders treatment services through reimbursement and billing. Massachusetts funded the nurse care managers and provided technical assistance and case consultation for the nurses.

To gauge our success, we studied MassHealth clients who were prescribed buprenorphine and methadone. Ultimately, we found that overall expenditures were lower for these clients than for those with no treatment. We also found that clients on MAT had significantly lower rates of relapse, hospitalizations, and emergency room visits.

Another interesting finding was that younger and newer clients were coming for buprenorphine treatment.

Although we achieved some success in Massachusetts, across the country we have not fully used our primary care infrastructure as an access point for substance use disorder treatment. Primary care settings, including Federally qualified health centers and health centers within the

Departments of Defense and Veterans Affairs, offer rich opportunities for integration.

Once again, thank you, Senators. I look forward to discussing these and other points in depth this morning.

I am pleased to take any questions you may have.

Thank you.

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Notes

[1] Schwartz R, Gryczynski J, O'Grady K., et al, Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009, *American Journal of Public Health*, May 2013, Vol 103, No. 5.

[2] National Quality Forum Endorses New Consensus Standards on Evidence-Based Practices to Treat Substance Use Conditions 2007

[3] SAMHSA. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2012 -- Data on Substance Abuse Treatment Facilities* (December 2013).

[4] Knudsen, H.K., Abraham, A.J., and Roman, P.M. (2011). Adoption and Implementation of Medications in Addiction Treatment Programs. Journal of Addiction Medicine. 5(1): 21 – 27. doi:10.1097/ADM.0b013e3181d41ddb

[5] Hutchinson, E., Catlin, M., Holly, C., Andrilla, A., Baldwin, L.M., and Rosenblatt, R.A. Barriers to Primary Care Physicians Prescribing Buprenorphine. (2014). University of Washington, Department of Family Medicine, Research Section, Seattle, Washington (Conclusion section – page 1)